

ADOPTION ASSISTANCE AGREEMENT**DISTRIBUTION:**

Original: Adoptive Applicants

Copy: Agency file

NOTICE: This agreement describes the adoption assistance benefits you will receive for your adopted child. If you agree, you should sign the agreement on the back and return it to the adoption agency. If you disagree, please contact the adoption agency. If you and the agency cannot reach an agreement, you will receive a Notice of Action which explains how to ask for a state hearing to resolve the matter.

I/we, _____ and _____, have entered into an agreement with the _____ for adoption assistance for _____.

(NAME OF PARENT) (NAME OF PARENT) (NAME, ADDRESS, TELEPHONE NUMBER OF AGENCY) (NAME OF CHILD)

Under the terms of this agreement, Adoption Assistance Program eligibility is expected to continue from _____ until _____.

(DATE OF ADOPTIVE PLACEMENT) (EXPECTED ENDING DATE OF ELIGIBILITY - NOT DATE OF NEXT RECERTIFICATION)

This is (check one) ☐ a deferred agreement (complete Section II only) or ☐ an initial agreement or ☐ an amendment to the agreement dated _____.

(DATE OF INITIAL AGREEMENT)

Complete Section I or II as appropriate.**SECTION I**

1. Adoption Assistance Program payment of \$_____ per month are authorized from _____ until _____. The payments are being made to assist me/us in meeting _____ need for _____.

(BEGINNING DATE OF PAYMENT OR DATE OF CHANGE) (NEXT RECERTIFICATION DATE) (NAME OF CHILD)

(NEEDS TO BE MET BY ADOPTION ASSISTANCE PROGRAM)

2. \$_____ of each monthly payment is for _____. This part of the payment will continue only until _____ or when this service ends, whichever occurs first. I/We agree to this future reduction in benefits.

(SPECIFIC SERVICE(S))

3. Unless payments are ending because of age, _____ will send me/us a Recertification Information - Adoption Assistance Program form at least 60 days before the payments are scheduled to end.

(COUNTY WELFARE DEPARTMENT)

I/We will complete the form and return it to the _____. If I/we do not return the Recertification Information form, the adoption agency will conclude that I/we no longer need Adoption Assistance Program benefits and benefits will stop until I/we make a new request for assistance and enter into a new Adoption Assistance Agreement.

(ADOPTION AGENCY)

4. With my/our agreement, the adoption agency may increase or decrease the amount of Adoption Assistance Program benefits as my/our circumstances or the needs of the child change.

5. However, payments may not exceed the foster care payment, based on the state-set, state-participation foster care rates, which would have been made if the child had not been placed for adoption. The foster care payment that the child would have received may be reduced because all foster care rates are reduced; any specialized care increment which he or she might have received is reduced because of a change in age or condition; or other income is received by or on behalf of the child. If the Adoption Assistance Program payment exceeds the new foster care payment that the child would have received, the Adoption Assistance Program payment will be reduced to the new foster care payment amount.
6. Continuation of adoption assistance payment depends upon my/our legal responsibility for the support of the child and on continued receipt of that support by the child.
7. I/We agree to inform the adoption agency immediately if any of the following events occur:
- Our residence or our mailing address changes.
 - The child leaves the family home or we stop supporting the child.
 - Our financial circumstances change.
 - The child's needs change.
 - The services for which payment have been authorized stop or change.
8. I/We and the agency will reevaluate and, if appropriate, adjust the amount of assistance if any of the above changes occur. Failure to report these changes could result in an overpayment which may be recovered by a direct charge or a reduction in current and future Adoption Assistance Program benefits.
9. I/We understand that this agreement shall remain in effect regardless of the state in which I/we reside.
10. I/We understand that under the terms of this agreement the child is eligible for services under Titles XIX (Medicaid) and XX (Social Services) of the Federal Social Security Act. _____ will help the
(ADOPTION AGENCY)
child obtain these services if I/we live in or move to another state by providing information and referral services.
11. I/We understand that the child will not be eligible to receive Adoption Assistance Program benefits after he or she reaches the age of 18 years unless he or she has a mental or physical handicap which warrants continuation of payment to the age of 21 years.

SECTION II

I/We understand that _____ has _____ which
(NAME OF CHILD) (SPECIFY HEALTH PROBLEM)
may result in a future need for Adoption Assistance Program benefits. Although assistance is not needed at this time, I/we understand that after completion of the adoption, if I am/we are unable to meet the child's need related to this known medical condition, or physical, mental, emotional handicap or other health condition, I/we may request adoption Assistance Program benefits.

REASONS FOR ADOPTION ASSISTANCE PROGRAM ELIGIBILITY:

☐ Age ☐ Sibling Group Member ☐ Minority Ethnicity ☐ Mental/Physical Health Problem

CHILD'S AGENCY REPRESENTATIVE SIGNATURE	DATE	CHILD'S AGENCY NAME
ADOPTIVE PARENT SIGNATURE	DATE	FAMILY'S AGENCY REPRESENTATIVE (COOPERATIVE PLACEMENT ONLY) DATE
ADOPTIVE PARENT SIGNATURE	DATE	FAMILY'S AGENCY NAME
